

My Asthma Plan

ENGLISH

Patient Name: ~~X~~ _____

Medical Record #: _____

Provider's Name: ~~X~~ _____

DOB: ~~X~~ _____

Provider's Phone #: _____ Completed by: _____ Date: _____

Controller Medicines	How Much to Take	How Often	Other Instructions
		_____ times per day EVERY DAY!	<input type="checkbox"/> Gargle or rinse mouth after use
		_____ times per day EVERY DAY!	
		_____ times per day EVERY DAY!	
		_____ times per day EVERY DAY!	
Quick-Relief Medicines	How Much to Take	How Often	Other Instructions
<input type="checkbox"/> Albuterol (ProAir, Ventolin, Proventil) <input type="checkbox"/> Levalbuterol (Xopenex)	<input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs <input type="checkbox"/> 1 nebulizer treatment	Take ONLY as needed (see below — starting in Yellow Zone or before exercise)	NOTE: If you need this medicine more than two days a week, call physician to consider increasing controller medica- tions and discuss your treatment plan.

Special instructions when I am *doing well*, *getting worse*, *having a medical alert*.

GREEN ZONE

Doing well.

- No cough, wheeze, chest tightness, or shortness of breath during the day or night.
- Can do usual activities.

Peak Flow (for ages 5 and up):
is _____ or more. (80% or more of personal best)

Personal Best Peak Flow (for ages 5 and up): _____

PREVENT asthma symptoms every day:

- Take my controller medicines (above) every day.
- Before exercise, take _____ puff(s) of _____
- Avoid things that make my asthma worse. (See back of form.)

YELLOW ZONE

Getting worse.

- Cough, wheeze, chest tightness, shortness of breath, or
- Waking at night due to asthma symptoms, or
- Can do some, but not all, usual activities.

Peak Flow (for ages 5 and up):
_____ to _____ (50 to 79% of personal best)

CAUTION. Continue taking every day controller medicines, AND:

- Take _____ puffs or _____ one nebulizer treatment of quick relief medicine. If I am not back in the **Green Zone** within 20-30 minutes take _____ more puffs or nebulizer treatments. If I am not back in the **Green Zone** within one hour, then I should:
- Increase _____
- Add _____
- Call _____
- Continue using quick relief medicine every 4 hours as needed. Call provider if not improving in _____ days.

RED ZONE

Medical Alert

- Very short of breath, or
- Quick-relief medicines have not helped, or
- Cannot do usual activities, or
- Symptoms are same or get worse after 24 hours in Yellow Zone.

Peak Flow (for ages 5 and up):
less than _____ (50% of personal best)

MEDICAL ALERT! Get help!

- Take quick relief medicine: _____ puffs every _____ minutes and get help immediately.
- Take _____
- Call _____

Danger! Get help immediately! call 911 if trouble walking or talking due to shortness of breath or if lips or fingernails are gray or blue. For child, call 911 if skin is sucked in around neck and ribs during breaths or child doesn't respond normally.

Health Care Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. Student may self carry asthma medications: Yes No self administer asthma medications: Yes No (This authorization is for a maximum of one year from signature date.)

~~X~~ _____
Healthcare Provider Signature

~~X~~ _____
Date

Controlling Things That Make Asthma Worse

SMOKE

- Do not smoke. Attend classes to help stop smoking.
- Do not allow smoking in the home or car. Remaining smoke smell can trigger asthma.
- Stay away from people who are smoking.
- If you smoke, smoke outside.



DUST

- Vacuum weekly with a vacuum with a high efficiency filter or a central vacuum. Try to make sure people with asthma are not home during vacuuming.
- Remove carpet if possible. Wet carpet before removing and then dry floor completely.
- Damp mop floors weekly.
- Wash bedding and stuffed toys in hot water every 1-2 weeks. Freeze stuffed toys that aren't washable for 24 hours.
- Cover mattresses and pillows in dust-mite proof zippered covers.
- Reduce clutter and remove stuffed animals, especially around the bed.
- Replace heating system filters regularly.



PESTS

- Do not leave food or garbage out. Store food in airtight containers.
- Try using traps and poison baits, such as boric acid for cockroaches. Instead of sprays/bombs, use baits placed away from children, such as behind refrigerator.
- Vacuum up cockroach bodies and fill holes in with caulking or copper wool.
- Fix leaky plumbing, roof, and other sources of water.



MOLD

- Use exhaust fans or open windows for cross ventilation when showering or cooking.
- Clean mold off hard surfaces with detergent in hot water and scrub with stiff brush or cleaning pad, then rinse clean with water. Absorbent materials with mold may need to be replaced.
- Make sure people with asthma are not in the room when cleaning.
- Fix leaky plumbing or other sources of water or moisture.



ANIMALS

- Consider not having pets. Avoid pets with fur or feathers.
- Keep pets out of the bedroom of the person with asthma.
- Wash your hands and the hands of the person with asthma after petting animals.

ODORS/SPRAYS

- Avoid using strongly scented products, such as home deodorizers and incense, and perfumed laundry products and personal care products.
- Do not use oven/stove for heating.
- When cleaning, keep person with asthma away and don't use strong smelling cleaning products.
- Avoid aerosol products.
- Avoid strong or extra strength cleaning products.
- Avoid ammonia, bleach, and disinfectants.



POLLEN AND OUTDOOR MOLDS

- Try to stay indoors when pollen and mold counts are high.
- Keep windows closed during pollen season.
- Avoid using fans; use air conditioners.



COLDS/FLU

- Keep your body healthy with enough exercise and sleep.
- Avoid close contact with people who have colds.
- Wash your hands frequently and avoid touching your hands to your face.
- Get an annual flu shot.

WEATHER AND AIR POLLUTION

- If cold air is a problem, try breathing through your nose rather than your mouth and covering up with a scarf.
- Check for Spare the Air days and nights and avoid strenuous exercise at those times.
- On very bad pollution days, stay indoors with windows closed.

EXERCISE

- Warm up before exercising.
- Plan alternate indoor activities on high pollen or pollution days.
- If directed by physician, take medication before exercise. (See Green Zone of Asthma Action Plan.)

Child Care Asthma Plan

Health Care Provider: My signature provides authorization for the above written orders (on Page 1 of Asthma Plan Packet). I understand that all procedures will be implemented in accordance with state laws and regulations. (This authorization is for a maximum of one year from health care provider's signature date.)

X _____
Health Care Provider Name (printed)

() _____
Phone Number

X _____
Health Care Provider Signature (required)

X _____
Date

Parent/Guardian: I agree with the above asthma care plan and emergency plan. I will inform child care program if child's health status/medication changes.

Parent/Guardian Name (printed)

() _____
Phone Number

Parent/Guardian Signature

Date

Emergency Contact Information

Emergency Contact #1	Phone:
Name: _____	() _____
Relation: _____	
Emergency Contact # 2	Phone:
Name: _____	() _____
Relation: _____	
Emergency Contact # 3	Phone:
Name: _____	() _____
Relation: _____	

Staff Training Information

Staff Name	Trainer (parent or guardian)	Date

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Asthma Medication Authorization Form

Child's Name:	Date of Birth/Age:
Name of Medication: <p style="text-align: center; margin: 0;">albuterol</p>	Reason for Medication:
Medication Start Date: ___/___/___	Medication Expiration Date = Stop Date: ___/___/___
Times to be given: “See Care Plan”	Amount to be given: “See Care Plan”
Possible Side Effects:	Route: <input checked="" type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
<input type="checkbox"/> Above information consistent with label?	Requires Refrigeration: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Special Instructions:	

Health Care Provider Name (please print)

() _____
Phone Number

Health Care Provider Signature

Date

Parent/Guardian Name (please print)

() _____
Phone Number

Parent/Guardian Signature

Date

Child Care Program Staff: This form is active for a maximum of one year from health care provider's signature date (above), and should be renewed annually, or sooner if there are changes to medication or health condition. **Authorization form is active from:** ___/___/___ to ___/___/___.



Medication Record

(Must be filled out by the person who gives the medication)

Child's Name:

Name of Medication:

Date	Time	Dosage	Initials	Reason NOT Given	Side Effects Observed

Initials and signatures of persons giving medication:

